Medi-Cal Provider Enrollment
Frequently Asked Questions

The questions are grouped and organized into the following topics:

APPLICATION PACKAGE

What are the requirements for enrollment in the Medi-Cal program?
Providers must be licensed and accredited according to the specific laws and regulations that apply to their service/provider type. Providers seeking enrollment in the Medi-Cal program to be eligible for reimbursement for services provided to Medi-Cal recipients must submit a complete application package, specific to their provider type. Provider enrollment regulations, *California Code of Regulations*, Title 22, Section 51000 et. seq. and Section 51200.01, amended effective February 3, 2003, list the application criteria which include having an established place of business and proof of liability insurance coverage and professional liability insurance coverage, as required.

Where can potential providers obtain the enrollment applications?
Providers may obtain provider application packages by contacting the EDS Telephone Service Center at 1-800-541-5555 for the forms to be mailed or by downloading and printing them from the Medi-Cal Web site's (**www.medi-cal.ca.gov**) Provider Enrollment page.

Can an applicant or provider talk to someone if s/he has questions about filling out an application?
Applicants are encouraged to carefully read the application instructions provided with the forms. Due to staffing shortages, staff is not available to provide a status update on the processing of applications or to assist with general questions. In addition, staff does not provide advisory opinions. The Provider Enrollment automated phone system, (916) 323-1945, may provide information that answers an applicant's questions. Applicants or providers may submit questions in writing to:

Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

The Department of Health Services will provide a written response.

Can an applicant or provider submit a photocopy of the application package?
A photocopy of the application is acceptable; however, the signature must be an original. Stamped, faxed or copied signatures are not acceptable. Although the form may be photocopied, it is unlawful to alter it in any manner. If a mistake is made entering information on a form, line through the mistake and initial it. Do not use correction tape, white out, etc. to make corrections.

Who can sign the enrollment application package?
The package must be signed under penalty of perjury by an individual who is the sole proprietor, partner, corporate officer or an official representative of a governmental entity or non-profit organization, and who has the authority to legally bind the applicant seeking enrollment as a Medi-Cal provider. A biller or office manager is not a valid signatory.

Include a legible, current copy of the driver's license or state-issued identification card of the authorized person signing the application. Enlarged copies work best.

Where does an applicant or provider submit the completed application package?
Completed forms should be sent to:

Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

Can the applicant or provider submit the application package by fax for processing?
No. Applications must have original signatures. Stamped, faxed or copied signatures are not acceptable.

What happens if all the required information is not included in the application?
An application package that is incomplete will be returned to the applicant. If new regulations or statutes become effective during the application review, the applicant will be given the opportunity to submit any new required information. All Medi-Cal providers are expected to comply at all times with all current statutes and regulations governing the Medi-Cal program.

What happens if an applicant or provider does not return his/her corrected application package to the Department within 35 days as specified on the initial notification that the application package is incomplete?
If the applicant returns his/her corrected application package to the Department of Health Services (Department) after the specified 35 days, the application is treated as a new application and the 180-day application process clock starts over again. However, if the complete application package with all required and requested documentation is received within the 35 days of the initial notice, processing continues.

Which officials in a non-profit organization must be reported on the *Medi-Cal Disclosure Statement* (DHS 6207)?
Most non-profit organizations are run by a governing board (e.g., Board of Directors). As such, each member of the applicable governing board must be reported. Additionally, although the vast majority of non-profit organizations do not have owners, any individual who owns at least 5 percent of the non-profit organization must be reported.

PROVIDER NUMBERS

How does a provider of health services obtain a Medi-Cal provider number?
To receive a Medi-Cal provider number, the appropriate application package must be submitted. For example, a physician new to Medi-Cal must submit a DHS 6210 form (*Medi-Cal Physician Application/Agreement*), a DHS 6207 form (*Medi-Cal Disclosure Statement*), and the required attachments, including a copy of a driver's license or state-issued identification card, a copy of his/her medical license, a copy of the certificates of insurance for liability insurance coverage and professional liability insurance coverage, and other documentation as listed on the DHS 6210. All other provider types are required to submit a separate DHS 6208 (*California Medical Assistance Program [Medi-Cal] Provider Agreement*) in addition to the applicable provider application form, *Medi-Cal Disclosure Statement*, and requested attachments.

How is a provider notified of the new provider number?
Providers receive a notification letter when the application is approved and entered into the system. The letter is mailed to the business address listed on the application. Approval letters contain the new provider number, the effective date of enrollment, and the address at which the services are provided. However, rendering providers to a group are not individually notified.

How long does the application process take before an applicant receives a provider number?
Applications are reviewed based on the date received. Timeframes for processing an application package are specified in statute, W & I Code, Section 14043.26, and regulation, CCR, Title 22, Section 51000.50. Within 30 days of receipt of an application package, a letter verifying receipt is mailed to the applicant or provider. Within 180 days, the applicant is notified in writing of one of the following:

- The application is approved for enrollment as a provisional provider,
- The application is incomplete and additional information is required,
- The application is referred for a comprehensive review and background check, or
- The application is denied with the reason(s) for denial.

As long as the applicant or provider responds within 35 days of the notice that the application package is incomplete, processing continues. Within 60 days of receipt of the resubmitted complete package, notification of approval, referral for comprehensive review and background check, or denial is mailed to the applicant or provider. This notice is mailed to the service or business address listed on the application.

How are group provider numbers assigned?
Group provider numbers are assigned to each physical location that delivers services to Medi-Cal recipients. For example, If a group practice has five sites, each site is required to submit a separate group application package and receive a separate provider number. Rendering providers to a group already enrolled at one location do not need to submit an application for the additional locations.

When can a provider number be deactivated without notification?
A provider number shall be deactivated when either (1) warrants or documents mailed to the service or business address or the pay-to address were returned by the United States Postal Service as not deliverable, or (2) a claim has not been submitted for reimbursement from the Medi-Cal program for one year. Prior to deactivating a provider number for either of the stated reasons, the Department of Health Services makes an attempt to contact the provider by telephone or writing. If unable to make contact, the Department is required to deactivate the provider number immediately without prior notice.

For additional information about deactivation for returned mail, please refer to W & I Code, Section 14043.62(a) for the full text of the statute and the *Provider Guidelines* section of the Part 1 manual.

For additional information about deactivation for non-participation, please refer to W & I Code, Section 14043.62(a), the *Provider Guidelines* section of the Part 1 manual, and the December 2003 *Medi-Cal Update* article, "Inactivation of Non-Participating Providers: Reminder."

When deactivated for returned mail or billing inactivity, how can a provider number be reactivated?
Submission of a complete application package specific to the provider type is required.

(Deactivation due to Department sanctions is subject to specific qualifications not discussed here. Detailed information is included with the written notification to the sanctioned provider.)

What are the important points to remember about the unique provider number?

- Each provider has agreed to abide by all Medi-Cal laws and regulations and the program policies and procedures as published in the Medi-Cal Provider Manual. Title 22 of the *California Code of Regulations*, Section 51501(d) states in relevant part:

  No provider shall submit claims to the Medi-Cal Program using any provider number other than that issued to the provider by DHS.

- Remember that without approval of the Medi-Cal application and the issuance of a provider number or provisional provider number, the decision to see Medi-Cal patients is at the applicant's own personal risk for payment.

- Provider Agreement Item 33 addresses the issue of assignability:

  Assignability. Provider agrees that it has no property right in or to its status as a Provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that Provider may not assign its provider number, or any rights and obligations it has under this Agreement.

IMPACT OF SENATE BILL (SB) 857
(Statutes of 2003, Chapter 601)

What are the process changes in provider enrollment?
Senate Bill (SB) 857 significantly amends the law used by the Department of Health Services (Department) to review applications for participation in the Medi-Cal program. One major change establishes a new provisional provider status. This new status enables the Department to enroll qualified providers more efficiently and remove problem and fraudulent provisional providers more quickly.

What applications will be subject to the new provisions?

- New applicants, existing providers undergoing continuing enrollment, and existing providers moving or adding a new location must submit a complete application package.
- Applications received before May 1, 2003 and not approved, denied or referred for background checks before January 1, 2004 will be granted provisional provider status effective January 1, 2004.
- Applications received on or after May 1, 2003 and before January 1, 2004 and not approved, denied or referred for background checks before January 1, 2004 will be deemed to have been received on January 1, 2004 and processed under the new provisions within 180 days.
- All applications received on or after January 1, 2004 are subject to the new provisions of SB 857.

What is preferred provider status?
The Department has identified criteria for physicians requesting preferred provider status. These criteria are listed in *Welfare & Institutions* (W & I) Code, Section 14043.26(c)(2). In order to request enrollment as a preferred provider, an applicant must currently meet all of the following criteria at the time s/he submits an application package to the Department:

1. Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which has not been revoked, whether stayed or not, suspended, placed on probation, or subjected to other limitation; and
2. Meet at least one of the following:
    - Be a current faculty member of a teaching hospital or a children's hospital as defined in W & I Code, Section 10727, accredited by the Joint Commission for Accreditation of Healthcare Organizations or the American Osteopathic Association;
    - Be credentialed by a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975;
    - Be credentialed by a county organized health system; or,
    - Be a current member in good standing of a group credentialed by a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975; and
3. Have full, current, unrevoked, unsuspended privileges at a general acute care hospital accredited by the Joint Commission for Accreditation of Healthcare Organizations or American Osteopathic Association; and
4. Have no adverse entries in the Healthcare Integrity and Protection Data Bank/National Practitioner Data Bank (HIPDB/NPDB).

The applicant or provider requesting preferred provider status will be notified within 90 days of the request by the Department. Preferred provisional provider status will be granted for a period of no longer than 18 months.

What is the benefit of having a preferred provider status?
With a preferred provider status, enrollment for participation in the Medi-Cal program can be accomplished within 90 days, if all requirements for enrollment are met.

How do I request to be considered for preferred provider status?
Instructions are provided in the February 2004 *Medi-Cal Update*. Periodically refer to the Medi-Cal Web site at **www.medi-cal.ca.gov** and click the "Provider Enrollment" link for updated instructions.

What if I do not qualify as a preferred provider?
Within 180 days of the date of the notice to an applicant that s/he does not qualify as a preferred provider, the applicant will be notified in writing of one of the following actions:

- The application is approved for enrollment as a preferred provisional provider,
- The application is incomplete and additional information is required,
- The application is referred for a comprehensive review and background check, or
- The application is denied with the reason(s) for denial.

What is provisional provider status?
Provisional provider status allows the Department to more thoroughly monitor newly enrolled providers. Provisional provider status will last up to 18 months for preferred providers and up to 12 months for all other providers.

REPORTING CHANGES TO PREVIOUSLY SUBMITTED INFORMATION

How does a provider notify the Department of change to an existing provider's entity type? (i.e. change from sole proprietor to incorporated or a partnership)
Changes in entity type require the submission of a new complete application package specific to the provider type.

How does a provider notify the Department of a change to an existing provider file?
A provider is responsible for notifying the Department within 35 days of any change in previously submitted information. Failure to do so may result in deactivation. A provider is required to submit a completed *Medi-Cal Supplemental Application* (DHS 6209) to:

- Add or change a business telephone number;
- Add or change its Medicare billing number;
- Add or change its tax identification number;
- Add or change the name under which the provider is doing business (DBA);
- Add or change the CLIA number;
- Add or change a pharmacist-in-charge, if the provider is a pharmacy;
- Add or change business activities, if the provider currently provides durable medical equipment and/or incontinence medical supplies and:
  - The change requires the issuance of a new license, permit or certificate, or
  - The provider is adding or deleting incontinence medical supplies;
- Add or change the following, for providers of medical transportation services:
  - Vehicle or aircraft information,
  - Driver or pilot information,
  - The days and/or hours of operation of the provider's business,
  - The geographic area(s) served;
- Request the deactivation of a provider number or group provider number;
- Request re-issuance of a Provider Identification Number (PIN);
- Delete a rendering provider from a provider group;
- Report a change of less than 50 percent in the ownership or control interest of a provider or provider group. (A change of 50 percent or more in the ownership or control interest of a provider or provider group requires the submission of a new application.)
- Change the pay-to address or address where the provider would like payments sent.

For a change of business address, please refer to the next question.

How does a provider notify the Department of a change in address for an existing location?
Effective January 1, 2004, a provider that is (1) changing location and moving to a different location than that for which the provider was issued a provider number, or (2) adding an additional location to that currently used to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries, and for which the provider was issued a provider number, shall submit a complete application package. (W & I Code, Section 14043.26 (a) (1)).

This does not apply to licensed clinics, licensed health facilities, licensed adult day health care providers, licensed home health agencies and licensed hospices (W & I Code, Section 14043.26).

How does a provider terminate enrollment as a Medi-Cal provider?
A Medi-Cal provider number can be terminated by the submission of a *Medi-Cal Supplemental Application* (DHS 6209) requesting to deactivate a provider number under the "Miscellaneous" section.

How do physicians join or leave a group?
If a physician is joining a group, a *Medi-Cal Physician Application/Agreement* (DHS 6210) and a *Medi-Cal Disclosure Statement* (DHS 6207) must be submitted requesting to "Add rendering provider to provider group." Be sure to include the group provider number on the application.

To discontinue participation in a group, submit a *Medi-Cal Supplemental Application* (DHS 6209) requesting to deactivate a provider number under the "Miscellaneous" section. Be sure to include the group provider number on the application.

BILLING FOR SERVICES

When can a provider begin billing for services furnished to Medi-Cal recipients?
Prospective Medi-Cal providers must apply for and be enrolled in the Medi-Cal program, be assigned a provisional provider number and agree to conditions of participation before payment can be made for services furnished to Medi-Cal recipients. The effective date on the enrollment letter is the date a provider can begin billing for services. Prior to approval of the application and issuance of a provider number or provisional provider number, the applicant's decision to see Medi-Cal patients is at his/her own personal risk for payment.

Who can a provider contact with a question regarding billing and claims information?
Providers should contact the Telephone Service Center at 1-800-541-5555 or visit the Provider Relations Organization page on the Medi-Cal Web site at **http://pro.medi-cal.ca.gov/.**

MISCELLANEOUS

What protections does the Medi-Cal program have in place to keep out potentially fraudulent or abusive providers?
The review of an applicant's or provider's application package is a highly complex process that requires assessment of many elements of the application, including a review of the required supporting documentation, to determine eligibility for enrollment into the Medi-Cal program. Enrollment staff must also be familiar with applicable statutes and regulations. Staff performs various background checks depending on the provider type. Additionally, *Welfare and Institutions* (W & I) Code, Sections 14043.37 and 14043.7, state that the Department may conduct a background check of an applicant or provider for the purpose of verifying information. This background check may include an unannounced onsite inspection, a review of business records and data searches to ensure that the applicant or provider meets enrollment criteria.

Where can a provider find out more information about enrollment into the Medi-Cal program?
The Provider Enrollment Branch (PEB) encourages potential applicants and providers to review the forms and enrollment regulations available on the Medi-Cal Web site. The regulations contain a wealth of information, application criteria and terminology, processing timelines and notes regarding applicable statues, as well as the requirements for participation in the Medi-Cal program. Due to staffing shortages, the PEB staff is not available to assist with general questions and staff does not provide advisory opinions.

Do cellular phones qualify as a business telephone?
"Business telephone" means the telephone number at the business address of the applicant or provider. A beeper number, answering service, biller or billing service, pager, facsimile machine, answering machine or a cellular phone shall not be used as the primary business telephone.